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Substance misuse in pregnancy

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Introduction

Substance misuse during pregnancy adversely affects outcomes both medically and socially. Consequently, women with problem drug and/or alcohol use have potentially high-risk pregnancies. It is important that they are provided with multidisciplinary care, preferably community based, which addresses all their problems both medical and social, within a single service. The aim of management is stability rather than abstinence and objectives should be realistic and achievable.

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IN THIS ISSUE

The huge icrease in drug use that occurred during the 1980's was disproportionately large among women of reproductive age so both the numbers of drug using women and latterly their duration of drug use have increased. While drug use occurs throughout society the type and pattern of drug use that is associated with medical and social problems is closely associated with socio-economic deprivation. Deprivation (and associated lifestyles) and substance misuse both adversely affect the health of mother and baby so the effects are cumulative. Consequently women with problem drug and/or alcohol use have potentially high-risk pregnancies.

Attendance for antenatal care

Service use is less effective in association with both deprivation and substance misuse. Late booking for antenatal care by women with problem drug and/or alcohol use is variously attributed either to lack of awareness of pregnancy due to the menstrual disturbances and amenorrhoea that are common features of drug use or else simply to lack of motivation. However, it has been found that drug-using women are rarely unaware that they are pregnant. Equally non-attendance is due not to lack of motivation but to difficulty in attending services. Services may be inaccessible not only geographically but also administratively. A final barrier to attendance is the perceived attitudes of service providers and women who already feel guilty about their behaviour can be reluctant to attend services where they fear they will receive a hostile and judgmental response. They also want to be cared for by staff who are knowledgeable about drug use and its' problems. Consequently the many effective specialised maternity services for drug using women now established in the UK share a number of common features: access by any route to care delivered by non-judgmental staff who are knowledgeable about substance misuse and community based multidisciplinary care that addresses both medical and social problems.

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Welcome

We are fortunate to have a key-note article on pregnancy by leading expert, Mary Hepburn, worth its weight in gold as this is an area many practitioners feel uncertain about. As we continue our look at how the rest of the world is doing with drug treatment, we see that the UK is amongst the leaders in GP drug dependency care but with some way to go before in matches the likes of Australia. We take a look at the future of the enhanced roles of our primary care colleagues, in terms of both the new pharmacy contract and supplementary and independent prescribing.

As our SMMGP advisory team is busy around the country, we are picking up that shared care is doing well but that the role of the shared care coordinator needs some support as it is often key to the success of schemes. With this in mind, we have started a new advisory page with some top tips for successful shared care. As always Dr Fixit is hard at work in the surgery answering queries on Jackie who is presenting for an assessment and Paul who has returned for treatment after just leaving prison. With care planning also on the horizon we have a discussion and scheme outline for patient involvement in treatment planning using access to electronic health records.

Since we last wrote in terms of policy there has been a major addition to the field – the effectiveness strategy that was launched on the 30th June 2005, by the National Treatment Agency (NTA) outlining their direction of work until 2008. The strategy places a strong focus on the user's experience of treatment and improving quality. This is a very positive step forward, following from the NTA's initial focus on increasing treatment capacity and reducing waiting lists, the targets for which are largely on track to being met. The strategy will be underpinned by a review process undertaken by the Healthcare Commission in partnership with the NTA looking in particular at helping underperforming areas to improve.

Certainly, we shouldn't ignore what is a significant piece of central strategy. The NTA have a clear vision and work-plan, along with significant funding and political imperative to see implementation results by 2008.

Enjoy the issue. **Jean-Claude Barjolin, Editor**

The Effectiveness Strategy

The treatment effectiveness strategy aims to identify some of the factors critical to improving drug treatment under the themes of improving service users' journeys through treatment and improving local drug treatment systems.

"Treatment for drug misusers is neither simple nor magical. Like diabetes or weight problems, people need a plan and sustained commitment to change. "Better treatment" means competent delivery of appropriate services to the people who need them. The client, service provider, and commissioning agency have mutual obligations in this process. Although treatment organizations are always evolving, positive change requires deliberate attention and resources."

Prof Dwayne Simpson, director, Institute of Behavioural Research in Texas and co-author of DATOS (Drug Abuse Treatment Outcome Studies) at the NTA Effectiveness Strategy Launch 30th June 2005

Improving service user's journeys through treatment

Treatment works...yes but...

Whilst 'treatment works' has been a recent, simplified and useful mantra arising out of NTORS, the NTA is quite rightly pointing out that it is good treatment that works. Indiscriminate treatment packages and poor practice such as sub-optimal dosing, and over reliance on medication, can fail to meet many users treatment needs.

Access, retention and engagement

Speedy access to treatment has once again been highlighted as important with targets set for the first episode of treatment to be within three weeks (85% target by 2008), with local investigations if a client waits for more than six weeks. The strategy recognises the importance of engagement in treatment and the factors that support this such as the value of a positive therapeutic relationship, and the respectful treatment of patients as individuals and as partners in treatment planning. Clients need to be retained in treatment long enough for them to benefit (i.e. a minimum of 12 weeks in terms of substitute prescribing). These retention figures are less use to us in general practice because we tend to retain people wherever they are on their 'treatment journey'.

Opportunities for change – 'treatment' completion and/or community integration

The strategy states that most people approaching services, wish for some level of change or improvement and that few service users are treated indefinitely. This is one area of the strategy requiring clarification and development from a primary care angle - as it slips into taking 'treatment' as meaning substitute prescribing. This does not fully account for the majority of people for whom drug use is not primarily about opioid use. For primary care treatment is a wide host of things, in which substitute prescribing is a small, but important part.

Primary care and the drug treatment journey: Whilst much of the strategy may be conceived with drug treatment services in mind, it is important to note that primary care can be a constant reference point during a patient's journey through the treatment system. Within primary care the treatment journey does not finish. Longitudinal GMS health care provision and care coordination remains irrespective of destinations in the drug treatment journey metaphor as outlined in the strategy. GPs can remain continually involved in 'treatment' through:

- Information giving
- Needle exchange

- Harm reduction
- Management of hepatitis C and HIV
- Sexual health
- Referral
- Assessment
- Care planning coordination or input
- Long term substitute prescribing
- Community detoxification
- Relapse prevention
- Access to counselling/advice and social/welfare support (letters to housing, Benefits, DVLA, social services, employers/education)
- Aftercare and support
- Drug related health interventions and non drug related GMS for the patient and family members.

The strategy sets out to maximise opportunities for those who wish to be maintained on substitute medication to receive social support, education and employment opportunities. The strategy's emphasis is for all clients, either staying on long-term maintenance or exiting treatment, to return to work, education and secure housing.

Detoxification, rehabilitation and exit routes from treatment
Importantly, there is to be a focus on better exit routes from drug treatment for those who want this, including detoxification, rehabilitation, and wrap around support for social, housing, education and employment. Potential for misinterpretation exists here where pressure may be brought on patients to inappropriately detoxify or move on from substitution therapy too early. However the NTA have made it is clear this is not the intention and have emphasised that detoxification without planned aftercare is not good practice.

It is intended to expand inpatient detoxification and residential rehabilitation services and improve partnerships with housing, education and employment at national and local levels. Treatment systems will need to demonstrate well managed exit/entry routes into wider social and community support networks.

Care planning

Retention in treatment and care planning are to be central to the new strategy. Individual care plans are to be developed to manage more effective and individualised treatment outcomes. These will track and regularly review progress in partnership with the client. Emphasis is to be on an individual's holistic needs and as such care planning is intended as a quality driver to maximise treatment benefits to enable clients to access the range of drug treatment and social care (e.g. support for housing, employment, education) they need to improve their lives.

As described, care planning once adapted to the practicalities of primary care has merit. However, how this fits into the day to day running of general practice requires clarification. Evidently within care planning there is a strong slant towards the performance management of social reintegration and community regeneration. Current care planning in other services can be experienced as the redirection of patient from point to point and it is important that primary care remains a constant in the patient journey. A national toolkit on care planning and training initiatives will be delivered along with guidance in the updated DH Clinical Guidelines due out by 2006.

Improving local drug treatment systems

Service reviews and inspection audit targeted at commissioners and services.

The NTA quite rightly acknowledges that the quality of drug treatment is very variable and often inconsistent with evidence based good practice. They have highlighted a dramatic if not surprising 7:1 quality ratio between the best and the poorest performing services. Correspondingly, patient treatment outcomes are acknowledged to be significantly associated with the quality of service provision rather than how individual service users present.

What is important here is that the focus is shifting directly onto poorer commissioning practice and raising the standard of poorer performing services. A programme will be implemented to improve commissioning skills. More consistent and proven commissioning approaches will be promoted, together with investment in and performance management of drug treatment systems as opposed to individual services. The introduction of targeted reviews of commissioning and service provision in localities through the Health Care Commission (in partnership with the NTA) is an example of this.

How They See It

"This is the most useful strategy yet to improve drug treatment – assuming it is actually put into practice. The services must exist for the benefit of the user, not the staff. How a drug user appears when they come forward for treatment initially is not an indication of who they are, but where they are in their life. It is imperative to address all aspects of a user's life in order to bring about real change." Anna Millington. National User Advisory Group

'Drug treatment should be about lifestyle change. It's not about being abandoned on a maintenance prescription. While we have made good progress on expanding availability, too many people are getting stuck in treatment with limited progress. That's not what service users, their carers or society want or need' Paul Hayes, Chief Executive NTA.

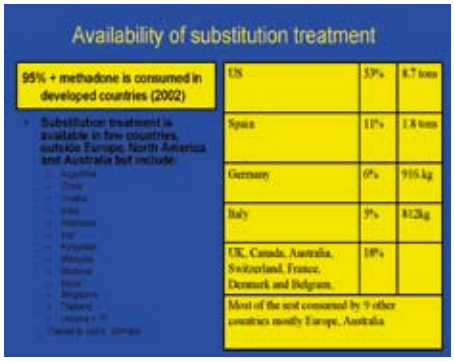
Substitute prescribing in Primary Care from a Global Perspective

Dr Chris Ford

We know that more than 15 million people use opioids (9million heroin) and many of those inject these drugs. We also know that substitution maintenance treatment is an effective, safe and cost-effective modality for the management of opioid dependence and the prevention of HIV among injecting drug users.

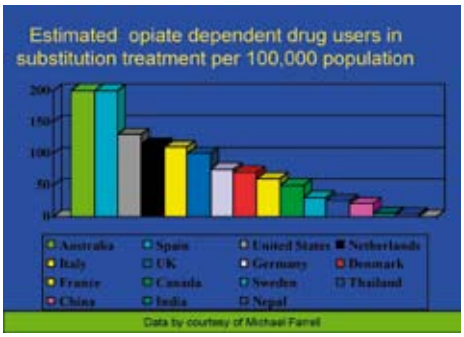
So where is this substitute prescribing taking place worldwide and how much of it is taking place in general practice?

There is an enormous variation in substitute prescribing worldwide in the treatment setting, quality of treatment, availability of harm reduction, injecting equipment and treatment for hepatitis and HIV. Although substitution therapy has increased in the last decade, still most harm reduction and treatment resources go to 20% of the worlds IDU's in rich countries. Over 95% of methadone is consumed in developed countries and over half in the US. But almost none of this US drug treatment takes place in office-based practice, the nearest US equivalent to general practice. Many countries have little to no treatment and/or lack of choice where it can be provided. Other countries are uncertain and ambivalent over if and where treatment should occur.



Hopefully there is no need to explain to this audience why primary care is a good place to provide substitute prescribing but I would include research data that we can care for the individual rather than the condition and we care for people long-term, wherever they may be in there drug history or at whatever stage they are in their treatment journey.

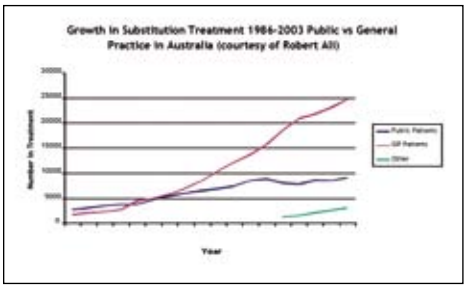
A systematic review of quality of care (for all types of conditions) in general practice concluded: *'The published research in the field presents an incomplete picture of the quality of clinical care'* But a substantial number of well-designed studies exist comparing care by GPs to that of specialists, which show *'no significant difference in quality of care and health outcome for care delivered by GPs even when substituted for secondary care specialists.* ***Primary care physicians are more likely than specialists to provide continuity and comprehensive care resulting in improvedhealth outcomes'.***



So how much of the worlds substitute prescribing in drug treatment is occuring in primary care?

Primary care, general practice varies enormously between countries and there are very wide differences in substitute prescribing between countries.

Australia

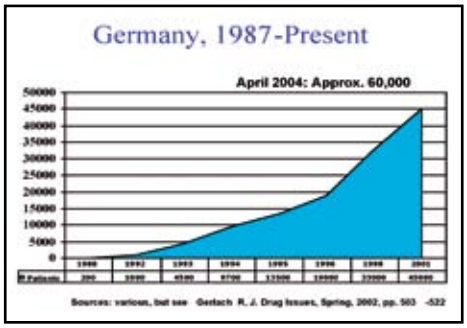


In 2003 in Australia there were approximately 38,000 people in substitute prescribing treatment and 25,500 (67%) were with GPs; 9,000 (25%) in specialist clinics and 7% were being treated in prison. 66% of all patients were receiving their doses in community pharmacies

Europe

Across Europe thepicturevaries enormously with a proportion of care done in general practice in Austria, Belgium and France but virtually all of it being done in specialist centres in Italy, Portugal and Spain.

Germany

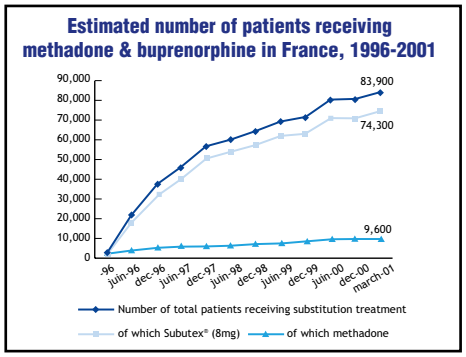


Substitute prescribing in Germany has increased exponentially dramatically. In April 2004 there were approximately 60,000 in treatment

(including methadone, codeine, buprenorphine) and 90% of this was being provided by community-based private practitioners: 70% GPs; 20% internists; 6% psychiatrists and 4% of others. **(Gerlach R. Journal of Drug Issues. Spring, 2002, p.514)**

Croatia

In Croatia treatment started in 1991 in General Practice and GPs remain the mainstay of MMT. Of the 2,400 GPs nationally, over 1,000 provide MMT. They have high retention between 70-80% and a country with an estimated 15,000 heroin users, 7,000 get treatment **(Ivancic SEEA Addiction 4(1-2):15-17, 2003)**



France

In France, before buprenorphine was introduced there was little happening in general practice, mainly because GPs were not allowed to prescribe methadone without permission. Buprenorphine was introduced and GPs were allowed to prescribe it and the situation changed dramatically.

So how are we doing in England?

From NTA figures aapproximate numbers of people in treatment 2003-4 were 126,000 (reported to NDTMS) and 2004-5: 140,000. It is largely unknown how many people are being treated in primary care. From NDTMS data it shows there is about 14.5% (9% last year) being treated but this is definitely an underestimate. From PACT data it appears to be about 16+% and from general practice audits, questionnaires and questimates it seems like the figure is between 25-30% being treated in primary care.

Summary

In summary there is a wide variation in availability, setting and quality of treatment worldwide. It is possible and practical in primary care because of long-term nature of the condition and the relationship with a stable service and with the right support and training providing treatment through primary care is a good and successful model.

Anyone from Ireland and Scotland wants to contribute with the situation from there or any foreign readers want to add in another country please write to us. **Ed.**

Connecting drug users to health

Some thoughts on patient involvement in treatment planning, and increased access to medical records, for patients in drug treatment in primary care

by Simon Morton (Tameside SMS), Dr Amir Hannan (GP, Hyde), and Dr Richard Fitton (GP, Hadfield, and GP member of the Care Record Development Board, NHS Connecting for Health)

The NTA has very recently published its new Effectiveness Strategy [1]. A key target is to improve care planning for drug users in treatment, and one explicit element is the call for the engagement of patients themselves in this process. This aspiration reflects the wider need to create a patient-led NHS. At the same time, the NHS has already begun the massive ten-year undertaking of a national programme for information technology (NPfIT, now renamed NHS Connecting for Health), which will completely reshape the information-related practicalities of treatment planning and delivery in primary and secondary care [2]. Face d with the question of what patient involvement in the planning of drug treatment and care actually means in practice, and how we can encourage this involvement, it may be that there are some lessons to be learnt (and possibly some clues as to the electronic shape of things to come) from e-work currently being done in primary care in Greater Manchester.

Two GP practices in Tameside and Glossop have been looking at a process whereby patients could be given a copy of their electronic health record for them to keep [3]. Patients are able to obtain a copy of all the information that is stored on the GP clinical system onto a floppy disk / CD-Rom. This includes demographic data (such as names, date of birth, address, telephone number, next of kin and their NHS number), all major and minor diagnoses, all allergies, all consultations on the computer, all blood results and other investigations, current medications as well as past medications given to them – essentially anything that has been recorded on the computer about them. Benefits that are appearing to be shown include developing a more open, more trusting relationship between clinicians and their patients. Also, patients have felt empowered to take more responsibility of their health-care whilst enabling them to ensure that mistakes in the health record (such as demographic data or clinical data that is incorrect or missing) can be highlighted.

The experiments being conducted in these two practices (and in other practices in the UK [4]) have only begun to scratch the surface of the positive contribution that this kind of improved access to patient information could make towards the therapeutic alliance. And what else could patients achieve by

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having a copy of their electronic health records? Could they present it to A&E, the Out-of Hours service, the local pharmacy or others? There may very well be other benefits that have as yet to be defined.

In preparation for this article, we sought views from colleagues working in primary care drug treatment about this issue, and there were a number of responses. Firstly, some bemusement about the point of this endeavour given that patients have had access to their medical records for over a decade. Secondly, weary and fatalistic reports that drug using patients would be uninterested in this level of information ownership, illustrated by examples of care plan copies simply discarded by patients after appointments. And finally, worry about the opportunities for data manipulation of patient held information unless it was read-only ("See Doc, I **am** on 60mg diazepam daily!").

For sure there may be challenges to promoting a greater degree of patient involvement in, and ownership of issues around, drug treatment information, and in particular around security and confidentiality. We think that practices or agencies that were considering similar projects would need to fully consider these sorts of potential obstacles, and perhaps others such as the management of the informed consent of patients who have a 'dual diagnosis', or of those receiving joint treatment from criminal justice agencies.

But while there may be some difficulties, there are surely benefits. We have a deputising-style model of shared care locally where Enhanced Service GPs treat drug users on behalf of other GP practices. It strikes us that there is great potential for the patient to be able to be an active participant in the sharing of information between the two GP practices about their blood borne virus status, and about the specifics of screening, treatment and management issues. Furthermore, in theory there is no reason why this potential could not be extended to the interface between other settings where important blood borne virus work is often undertaken, such as prisons.

"Prediction is difficult, especially of the future" is a quotation that may well be true but we predict that a future NHS information system that is more accessible to patients is not far away. Indeed it is arriving about……now[5].

[1] New drug treatment effectiveness strategy launched: focus on the service user's journey.

Press statement, 30 June 2005. Available at http://www.nta.nhs.uk/

[2] National Programme for IT in the NHS. Available at http://www.connectingforhealth.nhs.uk/

[3] Claire Harris,C and Boaden, R. Proof of concept of patients remotely accepting or rejecting the accuracy of their electronic health records. Available at http://www.nelh.nhs.uk/weeklydoc/ProofofConceptSummary.pdf

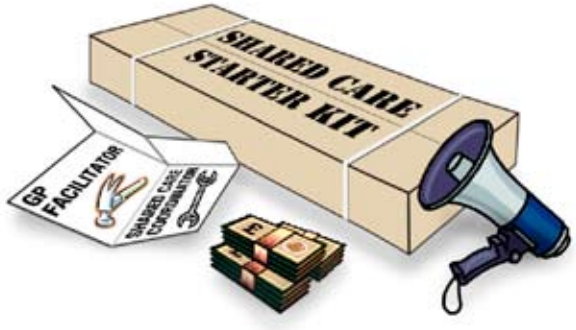
[4] PAERS: patient access to their electronic records. Information available at

http://www.london.nhs.uk/goodpractice/awards2003-paers.htm

[5] For further information about the issues raised by this article please contact Dr Richard Fitton at the Hadfield Medical Practice, 82 Brosscroft, Hadfield, Glossop, SK13 1DS; telephone 01457 868686; email richard.fittonl@btopenworld.com.

A new page for Network

Shared Care Coordination- How to make shared care schemes work



Welcome to this new page concerned with shared care coordination. We believe that the function of shared care coordination is essential to running a good scheme. However there is very little information around for those of you who are doing the job of Shared Care Coordinator, and sometimes a lack of recognition of the importance of the role. On this page we hope to share our own experience as SMMGP advisors to support the shared care coordinators role and we hope you will share your problems and how they were resolved as well as your successes! In this edition we will be concentrating specifically on what is involved in setting up a shared care scheme, with our own top 10 tips, together with an article about one area's experience of setting up a shared care scheme.

Why bother with a shared care coordinator?

Latest figures from the NTA suggest that primary care substitute prescribing is on the increase, with over 34% of GP practices now involved in substitute prescribing, a figure that has steadily been increasing over the past decade.

The Introduction of the RCGP Part 1 and 2 certificates has seen large numbers of GPs becoming trained in this area as well as a whole range of other disciplines including pharmacists, users, shared care workers and nurses completing Part 2. It would seem that the present and future of shared care is looking very promising and that we can sit back and enjoy the products of all our hard work knowing that increasing numbers of patients are receiving primary care based treatment.

However we are becoming increasingly aware of an area of primary care work that is frequently over-looked and essential to a successful and robust primary care based treatment system- shared care coordination. SMMGP has a small team of advisors whose job it is to support the development of good quality shared

care schemes. We work closely with the RCGP, the NTA and Drug Action Teams in order to do this, and the majority of our work falls into two main areas; supporting localities to set up new shared care schemes, and supporting areas in developing the quality of their schemes. In many cases it is the lack of coordination of a scheme that is holding back development, rather than a lack of willingness of GPs to engage with this patient group.

The successful running of a shared care scheme is a complicated business that involves a range of skills and knowledge. There are a number of professions involved in schemes, each with their own representative organisations, legislative requirements and cultures. Joint working will involve each profession understanding the other, and forums to communicate. A scheme will have to be agreed by the local PCT, DAT and treatment provider, and in the near future to be reviewed by the Healthcare Commission. Someone needs to be available to address issues as they arise. This work requires not only skill and knowledge, it takes up a lot of time. Our experience shows that the most successful schemes tend to have someone employed on a full time or part time basis specifically to carry out this role, complimented by a local GP lead.

Yet the function of coordinating a scheme can be undervalued, with no resources committed to the task. We therefore often find dedicated practitioners trying to coordinate schemes on top of their own jobs as GPs, managers, pharmacists, key workers or commissioners, often with limited success due to their lack of time and resources.

At the 10th RCGP conference we held a workshop for shared care coordinators which was attended by 50 practitioners from around the country.

The key issues identified at this lively workshop were:

- Shared care co-ordination is primarily a strategic and developmental role rather than a clinical one, involving multidisciplinary communication. The workshop did not agree with the practice of a clinician being given development of shared care as an 'add-on' role – it is important in its' own right.
- The need for growing recognition and professional development of the function with distinct roles and competencies. Training to support the demands of the job was identified as important.
- Many people were keen to network and form regional groups of shared care coordinators. For some it can be an isolated role with a lack of national guidance.
- **Stop Press**, Effective Coordination of Shared Care afternoon, MICC, Manchester, 26th April 2006 (day before the RCGP Conference) For more details or if you would like to contribute to the event please see the enclosed flyer or go to http://www.smmgp.org.uk/html/sharedcare.php

Making shared care systems work

What are the factors that commonly recur when schemes are facing difficulties? We have found there are many that are common. So here are our TOP TEN TIPS for helping to set up a robust shared care scheme:

Top Tips for Setting Up Shared Care

1. Make sure you talk to and obtain 'buy-in' from all involved and good communication between concerned parties – GPs, Pharmacists, drug users and DAT/DAAT, PCT, LMC, LPC, and specialist services.
2. Set up a shared care monitoring group (SCMG) with the above representatives.
3. Push for the appointment of a full-time shared care coordinator to bring all aspects of scheme together – this should preferentially be a dedicated person, with primary care and substance misuse experience who is best sited within the PCT rather than the specialist service.
4. Identify a local GP to champion the scheme – if you can employ a GP facilitator/GP lead for 2-3 sessions, even better.
5. Produce local protocols and guidelines – to be developed by the shared care monitoring group and led by shared care coordinator. Base these on national and other established best practice guidance. However, local arrangements need to reflect local history and politics.
6. Remuneration – remember GPs and Pharmacists are self-employed so additional work costs money if a payment scheme is not in place. Under the revised GP and Pharmacists contracts much substance misuse work is outside core work and needs to be costed.
7. Provide training and CPD of GPs and pharmacists which should include: RCGP Certificate in the Management of Drug Misuse Part 1 training for GPs and Centre for Pharmacy Postgraduate Education (CPPE) drug misuse distance learning programme for pharmacists are popular and signpost interested people to RCGP Certificate Part 2. All details on www.smmgp.org.uk
8. Make sure NTDMS forms are being completed and develop local audit systems via SCMG and the PCT…
9. …leading to clear clinical governance pathways within the PCT
10. Develop your local scheme and arrangements with local providers with a whole system approach in mind. Make sure everyone feels part of a joined-up service and knows who does what.

We believe that primary care can offer excellent care to patients within a supportive but flexible treatment system. However without the right support and coordination this will not happen. We therefore want to highlight the importance of shared care coordinators, and support the development of this role.

For those of you who want to get involved in this new area of our work

Please log on to our website and see our new page http://www.smmgp.org.uk/html/sharedcare.php

Contact us if you are interested in setting up a local network, or if you would like to contribute to this page or get involved with organising the conference.

Look out for our new series of briefing papers which will look in more detail at running shared care schemes.

Article by SMMGP Advisors Kate Halliday, Lisa Stanway, Chris Ford

We have SMMGP advisors to support you in your work wherever you are across England. Please contact the SMMGP office for further information or support. *(details on back page)*

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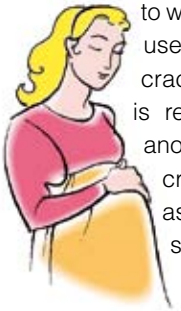
Effects of substance misuse on pregnancy

Since most of the women come from disadvantaged backgrounds and also have polydrug use it is not possible to study the direct effects of individual drugs on pregnancy in a controlled manner. Consequently the many published studies report varying outcomes. However it is apparent that few of the drugs commonly used directly affect pregnancy and that the adverse outcomes of pregnancy are multifactorial with deprivation together with associated factors such as smoking, poor diet, stress and chaotic lifestyle playing a major aetiological role. Among pregnant drug using women there are therefore increased rates of preterm delivery and low birth weight and an increase in sudden infant deaths. Heroin is short acting and withdrawal causes smooth muscle spasm. Consequently the fluctuations in blood levels that occur with even fairly regular use cause repeated minor degrees of withdrawal. This in turn increases the risk of preterm delivery (and in theory also spontaneous abortion although the latter is difficult to prove) while spasm of placental vasculature increases the risk of growth retardation.

The fear most frequently expressed by drug and alcohol using women is that their substance use will cause foetal anomalies but this is in fact uncommon. While there is a statistically significantly increased risk of cleft lip and palate with benzodiazepine use the absolute risk remains low. Cocaine use is reported to cause underdevelopment of brain, limbs or internal organs caused by vascular compromise due to the vasoconstrictor effect of cocaine. However, a bias towards reporting of adverse outcomes has been observed and major adverse effects due to use of cocaine are uncommon and confined to women with heavy chaotic use of cocaine, especially crack cocaine. Alcohol use is reported to cause foetal anomalies in the form of craniofacial abnormalities as part of foetal alcohol syndrome.



The other major concern expressed by pregnant drug using women is that the baby will develop withdrawal symptoms after birth. However, while tobacco and alcohol can cause minor withdrawals only opiates / opioids and benzodiazepines cause significant withdrawals that need treatment. There is an overall correlation between level of drug use and severity of withdrawal symptoms but this cannot be extrapolated to individual cases. It is therefore not possible to accurately predict which babies will develop severe withdrawals nor to draw conclusions about the level of the mother's drug use from the condition of the baby. Withdrawal symptoms are more severe with polydrug use, especially combinations of opiates / opioids and benzodiazepines, and are less severe if the baby is breastfed.

Management of substance misuse in pregnancy

Methadone remains the drug of choice for opiate / opioid substitution with proven medical and social benefits due to stabilisation of drug use and lifestyle and contact with services. During pregnancy it has the additional benefit that due to its long duration of action it reduces the risk of preterm delivery associated with heroin use but like heroin it can cause withdrawal symptoms in the baby. Buprenorphine is increasingly used as an opiate / opioid substitute and appears to be similar to methadone in its benefits and disadvantages. It has been claimed and is still widely believed that withdrawal from opiates / opioids during pregnancy is dangerous to the foetus and should only be undertaken slowly during the mid trimester. However, while in theory rapid opiate withdrawal might be risky, in practice this does not seem to be the case, with harmful effects limited to the continuous fluctuations of drug associated with heroin use. Detoxification can therefore be carried out at any stage of pregnancy and at any speed but should only be undertaken if appropriate and if there is a reasonable prospect of success. It should be emphasised to women that stability is more important than abstinence. Physiological factors are not always the most important in determining dosage required for stability. External factors play a major role and since these may not be constant throughout pregnancy, in practice it is necessary to continually monitor the dose and to increase or decrease it according to the woman's ability to cope. During the third trimester women become increasingly focused on the possibility of neonatal withdrawal symptoms so during this time many women succeed in making considerable reductions in dosage. It is therefore not helpful to have a strict regime for prescribing substitution therapy determined by theoretical considerations and management should always be tailored to individual needs.

Immediate detoxification from benzodiazepines carries a risk of maternal convulsion. Antenatal detoxification from benzodiazepines should therefore be carried out under cover of a short reducing course of diazepam and an initial dose of 10mg three times daily reducing by 5mg each day (rotating the dose to be reduced) has proved safe in practice. While this may not achieve long-term abstinence it does reduce exposure of the foetus and can be repeated – several times if necessary.

Withdrawal from alcohol can be safely managed with the same regime as used for benzodiazepine withdrawal. There is no evidence to support substitution therapy during pregnancy for any other type of drug.

Antenatal management

At the booking visit a detailed medical and social history should be taken. Any pregnant woman who admits to drug use past or present should have a detailed drug history taken including details of drugs used, amounts used, routes of use and financing of use. A sexual health screen should be carried out including cervical smear if due and screening for sexually transmitted infections.

All pregnant women need information about and the offer of screening for HIV and Hepatitis B and C. If not

immune a complete course of hepatitis B vaccination (accelerated course) can be given during pregnancy. Also, all babies born to drug using women should be routinely immunised regardless of their mothers' HBV status. Women infected with HIV should be offered interventions to reduce vertical transmission and managed according to national guidelines.

Drug using women have potentially high-risk pregnancies so their management should be obstetrically led but much of their care can nevertheless be delivered by midwives. While drug use carries an increased risk of growth retardation not all of these small babies are unwell and there is no evidence of benefit from routine ultrasound monitoring of growth.

All drug-using women should receive multidisciplinary management that addresses social as well as medical problems. While not all women will need formal social work allocation, drug use is a relapsing condition. Abstinence from illicit drugs at the time of booking is no guarantee of future stability, while prescribed drugs can also cause neonatal withdrawals and consequently make parenting more difficult. Regular ongoing review is therefore essential and a routine multidisciplinary planning meeting held at 32 weeks gestation will allow identification of actual or potential problems and planning of management. Such meetings should be concerned with family support and if child protection issues are identified these should be separately and appropriately addressed.

Intrapartum management

While most drug using women do not deliver prematurely, most go into spontaneous labour by term and most labour uneventfully. While they can be managed by midwives, they should be delivered in a hospital with facilities to manage neonatal problems including neonatal drug withdrawals.

Provision of appropriate analgesia often causes anxiety but such concern is usually unfounded in practice. Regional anaesthesia is a good method for drug using women but may be problematic if venous access is difficult. There is often reluctance to give opiate analgesia to women who are addicted to opiates / opioids, however there are no problems with this type of analgesia. While methadone has analgesic properties it is not a substitute for routine analgesia in labour. Conversely, opiate analgesia is not a substitute for methadone, which should be administered if due.

Use of heroin on top of prescribed methadone by women at or near term can precipitate labour and as in the antenatal period recent drug use can cause difficulties in interpretation of cardiotocography.

Postpartum management

After delivery, babies should go to the postnatal ward with their mothers unless there are medical reasons for their admission to the neonatal unit. Various scoring systems are used to dictate treatment of neonatal withdrawal symptoms. However these scores should not be rigidly interpreted and the ability of individual mothers to cope with their baby's condition should be taken into consideration. The development of neonatal withdrawal symptoms even if they require treatment is not in itself an indication for admission and treatment can be easily administered in the postnatal ward.

Drug using women have often been advised not to breast feed since the drugs pass into breast milk. However, babies of drug using women may be preterm, are often of low birth-weight and have an increased risk of sudden infant death. These babies therefore are particularly vulnerable and have most to gain from breastfeeding. The presence of the drugs in breast milk is in fact advantageous and an additional benefit is that breast-feeding will reduce the severity of neonatal withdrawal symptoms. While drug use should be stable for breast-feeding to be appropriate, successful establishment of breast-feeding is adequate evidence of stability. Breast feeding should therefore be encouraged regardless of the type of drug or dosage used and indeed the greater the level of drug use the greater the potential benefits of breast feeding. While breast-feeding will increase the risk of vertical transmission of HIV there is no evidence that this is the case with HCV infection and it is irrelevant with HBV infection since immunisation of the neonate will prevent transmission in almost all cases.

As already pointed out it is important that drug using women should be given appropriate information, advice and treatment to enable them to control their fertility and to ensure all pregnancies are intended, wanted and optimal in timing. It is therefore important that women are given appropriate contraception advice during pregnancy to enable them to choose a method by the time they deliver. Contraception should usually be initiated by the time of postnatal discharge from hospital.

Practice points

- Women with problem substance use have potentially high risk pregnancies, but rarely need high technology to deal with
- Women with problem substance use require community based, multidisciplinary care that addresses all their problems, medical and social within a single service
- Maintenance substitution therapy is only indicated for opiate/opioid use
- Stability is more important than abstinence
- Women with problem substance use should be encouraged to breast feed
- National guidelines have been produced for management of substance misuse in pregnancy

References

1. Hogg C, Chadwick T, Dale-Perera A, Drug using parents - Policy guidelines for inter-agency working (England and Wales). London: LGA Publications 1997.
2. Scottish Executive, Getting our priorities right: Policy and practice guidelines for working with children and families affected by problem drug use. Edinburgh: Scottish Executive 2003.

Starting from Scratch – Waltham Forest Primary Care Trust (PCT) Shared Care Service

Anna Hall, GP Liaison Worker, Waltham Forest PCT.

The east London Borough of Waltham Forest covers the localities of Leyton, Leytonstone, Walthamstow, Chingford, Highams Park and North Chingford. With diverse socio-economic populations and concentrated areas of black, and minority ethnic groups, the Waltham Forest average English Indices of Deprivation (IMD) score is 30.27. (London average = 24.30)[1]. The drug market is concentrated around the train and underground stations, Walthamstow shopping areas and three large estates across the borough.[2]

It is estimated that there are 1200 problematic drug users in the borough, giving an average of 7 users registered with each local GP (prevalence rates in some parts of the Borough will be significantly higher than others). Between May 2003 and April 2004, 14 out of 61 (23%) GP practices prescribed methadone. The local specialist service, Health Works, has a commissioned capacity of 140 prescribing places and works to full capacity.

In order to respond to growing need and increase capacity in line with the local development plan a shared care service was commissioned.

In March 2004, based on recommendations laid out in the Department of Health Drug Misuse and Dependence – Guidelines on Clinical Management, the Shared Care Monitoring Group (SCMG) was formed with a clear brief to establish formal shared care arrangements in the borough. Members include a GP prescribing for substance users, the local Professional Executive Committee pharmacist, Local Medical Council and Local Pharmaceutical Committee representatives, the Assistant Director of Primary Care, the Lead GP for Mental Health (Substance Misuse falls under the Mental Health Directorate in this PCT), representatives from Health Works and the voluntary Tier 2 service provider, a service user and a DAT member, represented by the Joint Commissioning Manager.

A survey was sent to all GPs and Pharmacists, exploring willingness to participate in Shared Care. The survey elicited the support mechanisms and incentives required to encourage participation and informed the end package offered by the PCT to meet local GP's and pharmacists needs. The PCT was able to commit to: training for GP's and pharmacists; commissioned training for staff; remuneration including pharmacy grants; a dedicated Liaison Worker and the provision of local guidelines.

The local guidelines were ratified by the PCT Clinical Effectiveness Group and complement at a local level the DH orange guidelines. As a resource for all GPs and pharmacists in the borough, they outline partnership working, role and responsibilities and are accompanied by a CD ROM containing referral pathways, primary care aide memoir and all feedback/communication forms between parties.

Training requirements for GPs are affiliated to service level agreements and remuneration. The SCMG voted for a 4-tier model (Figure 1), offering flexibility in commitment and choice for both the provider and the patient. The patient can move seamlessly between tiers in response to changing needs and stability, whilst the GP can move between service level agreements as their

Figure 1. Waltham Forest 4-Tier Model of Shared Care

Tier	Service Level Agreement	Components	Remuneration
1	Locally Enhanced (LES)	• RCGP Part 1 training • Own registered patients	Sum per patient per annum
2	Nationally Enhanced (NES)	• RCGP Part 2 or equivalent training • Own registered patients • Initiate treatment	Retainer + sum per patient per annum (no distinction between maintenance and withdrawal payments)
3	General Practitioner with Special Interest (GPwSI)	• Meets criteria for GpwSI status • Other GP's patients • Initiate treatment • More complex needs patients	
4	Health Works	• Refer back to specialist service facility	
Primary Care Based	GP Liaison Worker	• To provide advice and support to GPs and Community Pharmacists • Responsible for patient care coordination, assessment & ensuring effective communication between all parties. Close working links with Tier 2 & 3 service providers • Clinical supervision from Health Works	

Figure 2. 4-Tier Model

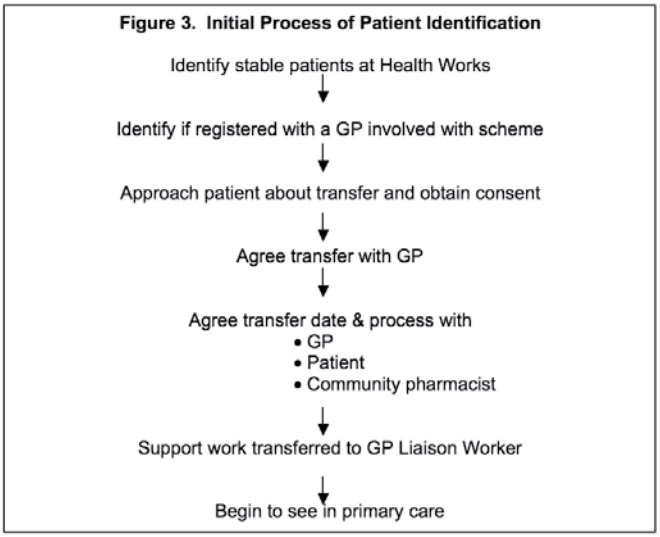
Pros	Cons / Barriers
Flexibility & Choice – the GP can choose the extent of involvement & remuneration accordingly	Transparency of the model can be called into question • Remuneration & retainer • Nature of the robust SLA's
Robust SLA	Resistance to the new treatment option from Tier 3, Tier 2 services
Choice for patients	Balance & boundaries between being PCT led but specialist service (Health Works) providing clinical support/supervision (GPwSI, GP Liaison Worker)
Clear pathways, roles responsibilities as laid out in the local guidelines	
Model's support structure – means GPs are not working in isolation.	
Primary Care based & led	

commitments and professional development plans change in response to practice demands.

Completion of the CPPE open learning course "Opiate Treatment: Supporting Pharmacists for Improved Patient Care" is the prerequisite for pharmacists joining the shared care scheme and to encourage participation the PCT dedicated funds towards one day locum costs. Furthermore, in an effort to ensure parity with neighbouring boroughs, the North East London Pharmaceutical Committee agreed to remunerate pharmacists providing supervised consumption services, under the East London DAT's payment structure.

In response to a shortage of private areas for supervised consumption in local pharmacies, 6 grants were awarded across the borough, towards construction of consultation rooms. Based on grant criteria including commitment to continuing professional development (CPD) and pharmacy needle exchange, applications were considered by an appointed panel of SCMG members. In support of CPD, it is envisaged the GP Liaison Worker offers specifically commissioned training to address identified training needs for practice staff, allied disciplines, pharmacy dispensers &

Figure 3. Initial Process of Patient Identification



counter staff. GPs and pharmacists CPD sessions, offered jointly with Redbridge, are matched to the service level agreement CPD requirements.

The processes involved in starting from scratch have inevitably informed future service developments. The simple patient identification process described in Figure 3., immediately highlighted the need to establish clearly defined roles for the GPwSI, an efficient patient tracking system and robust GP referral pathways. Predictably, service boundaries get challenged in an effort to squeeze unmet service needs into the remit of the scheme. Whilst the role of shared care in treating benzodiazepines and alcohol will be addressed within Waltham Forest our current service limitations should be acknowledged in light of the schemes' infancy.

With a robust structure as its' basis, a grounding within Waltham Forest PCT and dedicated financial resources, the shared care scheme has progressed forward since its' commissioning. By the time shared care was dropped as a star rating for the PCT, our motivated and influential stakeholders had already invested in driving forward the agenda within the community. An ongoing process of consultation has been maintained and importantly recommendations followed through. The assistance of SMMGP advisors and the RCGP Substance Misuse Team has been invaluable, as has working with neighbouring London boroughs and those in the South East in developing the scheme. Without the experience of our colleagues in shared care, their knowledge, openness in sharing information, guidance & wisdom, Waltham Forest Shared Care Scheme would not be in the position it is today.

References

[1] Towards Health Equity in Waltham Forest - Waltham Forest Primary Care Trust Public Health Report 2004/5

[2] Drug Markets in Waltham Forest - Interim Report - September 2002 - Russell Webster in partnership with Criminal Policy Research Unit at South Bank University

Nurse Prescribing within a Primary Care Setting

Jane Haywood, Team Leader, CLAS Team

For years nurses have played a pivotal role in the care of drug and alcohol users, supporting medical practitioners in the management of these patients – exciting times ahead and how will nurse prescribing increase this role?

To understand how the role of the nurse in substance misuse is changing – first we have to understand the scope of the professionals' responsibility and boundaries.

There are two main areas relevant to that of the specialist role in the area of prescribing: **independent prescribing** and **supplementary prescribing** – the later being most relevant.

Supplementary prescribing allows the nurse to take shared responsibility with the doctor for the on-going treatment of the patient. A Clinical Management Plan (CMP) is worked out between nurse and doctor – including the regime for medication. The nurse may then prescribe for the patient based on that care plan.

In independent prescribing – the nurse would take responsibility alone for creating a medication regime. However, at present nurses MAY NOT independently prescribe controlled drugs for the treatment of substance misuse...although medication for the alleviation of acute alcohol withdrawal has been added to the list of medications approved for independent nurse prescription - it would require a change in Home Office/DH regulations to extend the independent prescription of controlled drugs for the treatment of drug misuse to nurses.

So changes are being made in the scope of independent prescribing - but it is within the context of supplementary prescribing that the role of nurse specialist has really expanded. Recent amendments to the Misuse of Drugs Act 2001 - now permit the prescribing of controlled drugs within the context-shared responsibility with a primary prescriber ie a doctor. Although the Nurse is responsible for any prescriptions that he/she writes within this plan. In March 2005 it was announced that a Bill will go before parliament in respect of nurses being able to be independently responsible as a primary prescriber of controlled drugs.

Supplementary prescribing is NOT restricted to specific medical conditions but to an agreed treatment plan for the individual patient, to which he or she, has given consent. This is worked out between nurse, doctor and the patient and is subject to regular review.

For years nurses have played a pivotal role in the care of drug and alcohol users, supporting medical practitioners in the management of these patients. As health care moves into the 21st century, nurses and nursing care have the opportunity, extending from the General Medical Services contract and the NHS Plan, to develop specialist skills. This applies to many areas of specialism - and the care of drug and alcohol users is no exception.[1]

The 1999 Clinical Guideline discusses the role of the generalist:

"Their skills and techniques range from assessment of drug misusers, counselling and carrying out other treatment procedures, to health education and teaching. The clinical and treatment role in drug misuse services is as varied as it is essential."[2]

With roles expanding and changing so fast - this is an exciting time of opportunity for nurses working in the field. The changes have, of course been backed up by a range of accredited training programmes and modular packages, designed to suit the requirements of the nurse. But, as it stands, there are currently no specialist training courses that lead on from the rather generic Extended and Supplementary Prescribers training. With the complex legal and safety issues facing nurses working in addiction. It is expected that Nurses have the skills for the area that they work in. The non-medical prescribing course is purely to learn how to prescribe. It would seem timely to introduce measures of competency for all professionals in the field – and to standardise and disseminate guidelines for nurse prescribing in substance misuse. However, Nurses will be following the same guidelines for prescribing in substance misuse that the doctors use.

It also would appear common sense, at this critical point in the development of primary care led substance misuse treatment, to open a meaningful dialogue with those professionals in the field, to agree an appropriate way forward – particularly looking towards the areas of training, and competency measurement. (The Nursing and midwifery council are currently working on guidance for nurses on prescribing that will include controlled drugs).

From a positive perspective, from the point of view of the service, the advantage of nurses specialising in addiction are obvious in terms of numbers, time, specialist knowledge and the building of a therapeutic relationship between patient, doctor and nurse.

If targets are to be met, recruitment into the field has to be maximised. As a highly cost effective resource, nurses can dramatically enhance the delivery of continuous and "joined-up" care.

The National Treatment Agency's remit is to "increase the availability and effectiveness of treatment for drug misuse in England...and to double the number of people in effective, well managed treatment from 100,000 in 1998 to 200,000 in 2007." [3]

Using specialist nurses as the cornerstone of this expanded service, makes sense for the patient, the doctor, and the service itself in terms of delivering value for money.

Post Shipman, although there will be changes made to the way in which the prescribing of controlled drugs are scrutinised and audited, in terms of the what, who, how and when - there seems to be good and positive indictment for nurses to continue pursuing their potential in the scope of prescribing.

References

[1] Haywood, J and Harding-Price, D. Chapter: The Role of the Nurse. RCGP Guide to The Management of Substance Misuse in Primary Care. Ed Gerada, C. 2005

[2] Dept of Health. Drug misuse and Dependence; Guidelines on Clinical Management. London: DoH, 1999.

[3] National Treatment Agency. Models of Care for Treatment of Adult Drug Misusers. London: NTA, 2002.

For further information contact:

www.nta.nhs.uk

http://www.dh.gov.uk/PolicyAndGuidance/MedicinesPharmacyAndIndustry/Prescriptions/SupplementaryPrescribing/fs/en

What does the new Pharmacy contract mean for patients and GP's?

The new pharmacy contract (nGPS) came into effect in England from 1st April 2005, a year after the new General Medical Services (nGMS) contract. The structure of the (nGPS) is very similar to the GMS contract, in particular the three levels of service in addition to drug use being in a special category under enhanced services. The nGPS contract was designed to compliment the nGMS contract and developed with the expectation that community pharmacists would be enabled to play a greater role in supporting General Practitioners (GPs) and whislt providing services that would otherwise only be available to patients from their GP. The nGPS radically alters the way the NHS carries out business with local pharmacies and it changes the manner by which pharmacists work.

Why do we need a new contract? What was wrong with the old one?

The old contract was based solely on volume; the more prescriptions dispensed the higher the income. The aim of the nGPS is to cut incomes from the drug purchase profits made by pharmacists and to package these savings to pay for advanced services. The Government hopes that pharmacists will spend less time dispensing and more time providing other services.

The New Contract – What's New?

Under nGPS pharmacists will provide three tiers of service.

- **Essential services** are obligatory for all contractors and these will be phased in from April to October 2005.
- Pharmacies providing all the essential services can provide **advanced services** but accreditation of the pharmacist and the premises is required.
- **Enhanced services** are commissioned at the discretion of the Primary Care Trust (PCT) and this is based on local demand as identified from a pharmaceutical needs assessment or based on PCT priority areas.

Essential Services	Advanced Services	Enhanced Services
• Repeat dispensing and electronic transfer of prescriptions • Public health promotion – prescription linked interventions and campaigns • Signposting to other healthcare services • Support for self care • Support for people with disabilities • Achieving clinical governance standards • Hours of service (increase form 30 to 40 hours) • Emergency supplies for up to 1 month instead of 5 days	Medicines Use Review (MUR) • Every 12 months • As a result of a prescription intervention These MUR services aim to improve patients knowledge, concordance and use of medicines. A copy is sent to the GP along with any recommendations.	**Some examples are:** • Substance misuse services • Needle and syringe exchange schemes • Smoking cessation clinics • Supervised administration of other prescribed medication • Diagnostic testing • Full clinical medication review • Minor ailment schemes • Monitoring for long term diseases • Supplementary prescribing

The pros and cons

Do the advantages outweigh the disadvantages? I think so.

On the pro's side there will be better use of pharmacists' skills. Training, accreditation and clinical governance requirements should result in a improved quality service for patients, in addition to more privacy areas for discussion with the pharmacist. Longer opening hours in rural areas from 30 to 40 hours will also benefit access for patients.

On the cons side, pharmacies do still have to dispense large volumes of prescriptions in order to qualify for their practice payments. Therefore unless a pharmacy can afford to employ accredited checking technicians or an extra pharmacist they will probably not be able to participate in most of the advanced or enhanced services. Overall their income could be reduced because the profit from reimbursements for medication costs has been redirected to pay for the new services. My fear is that there may be a loss of some small pharmacies.

How new developments can support shared care and working with GPs

Substance misuse could be targeted as one of the long-term conditions and Medication Use Review (MUR) would then be conducted on a regular basis for all patients.

Under the public health criteria one of the 6 window campaigns could be aimed at substance misuse and pharmacists could be asked to give prescription-linked advice to all drug users.

Signposting – Some Drug Action Teams (DATs) are already providing booklets with information about substance misuse services such as GPs and drop–in centres. These are being placed in community pharmacies so that patients or the public can be directed to appropriate services. Going one step further, pharmacists could actually conduct a full referral and brief initial assessment. This could be faxed in advance of the patient attending the recommended service.

As part of an agreed treatment plan a pharmacist who is qualified and registered as a supplementary prescriber could, for example, prescribe missed methadone doses, a benzodiazepine or opiate detoxifications.

Linking in with the minor ailment scheme, a patient attending a pharmacy to collect their medication could also be given a voucher from their GP surgery. This voucher will enable the pharmacist to provide advice and supply treatment on the NHS for a minor ailment such as a cold or even symptomatic relief for opioid withdrawal symptoms during a detoxification or induction.

Where are things going in terms of pharmacy roles?

The community pharmacy will eventually be used as a first contact where the public can visit for public health information, diagnostic testing, obtain a prescription for a long term condition and many other routine and minor services that are currently only available form the GP surgery.

What is still needed in terms of guidance or developments

By October the National Service Specifications for the enhanced services should be available. These will contain details about accreditation requirements, the service outline and the remuneration for each service. Community pharmacists will be responsible for satisfying the required criteria and applying to their PCTs in order to provide these national and / or local services. Some services such as repeat dispensing and MURs may be postponed until developments such as electronic transmission of prescriptions are in place. In addition other services such as the provision of emergency supplies sufficient for a 1-month period will not be possible until there is a change in the Medicines Act.

Historically the community pharmacist has been an underused resource, however with this new framework and adequate training pharmacists can assist with moving the NHS modernisation agenda forward. This will benefit patients, GPs and other healthcare providers. More information about the new contract can be found on the PSNC website www.psnc.org.uk.

Sumbo Adeyemo
Clinical Pharmacist
Substance Misuse Services
CNWL MH NHS Trust

Dr Fixit on assessment in primary care

Dear Dr Fixit

Jacky, aged 32 years presented to me today and requested that I took her on for drug treatment. She had previously been at the specialist service but she was keen not to go back there because a previous partner was being treated there. She told me that she had been injecting about 1 gm of heroin / day, split into 3-4 doses and occasional crack and benzodiazepines. She wanted to stop all drugs.

I have been caring for drug users for 2 years now and enjoying the work. At the moment all the assessments are undertaken by the specialist service and then transferred to me. This system works well but I now feel able to take on people from the start.

I would like to help Jacky but could you explain the main areas I should cover in the assessment?

Well done for thinking about taking this on. It is helpful to undertake the assessment yourself as it will lead to a better understanding of Jacky.

The assessment is a key part of the treatment process. Many GPs like yourself initially start working as part of a traditional shared care scheme but over time take on an extended role with drug users in the primary care setting. The *Department Of Health Drug Misuse And Dependence – Guidelines On Clinical Management* give a full description of the assessment process and its aims in chapter 3 pages 17-25.

Assessment is the mutual gathering of information to assess Jacky's needs and to assist in defining the most appropriate course of action. It is an on-going process rather than a one-off event, as her needs evolve over time. As the NTA's (2002) *Models of Care for treatment of adult drug users states* 'Effective assessment needs to be tailored in terms of comprehensiveness and complexity in such a way that it does not present a barrier to entry to, and engagement in, appropriate drug and alcohol treatment.'

You have already begun Jacky's assessment. You have established that she is using drugs. You need to offer brief interventions that provide specific advice on risk and harm reduction and deal with any acute conditions. Next identify all the drugs, how much and what route she is using; identify what problems and concerns she has and assess her motivation. Try to determine if Jacky's drug use is causing health or social problems.

The full assessment process is in several parts:

A) The drug and medical history

B) Examination

C) Screening for drug use

D) Other investigations

E) Notification

A. The drug and medical history:

a) Her current drug use (last 4 weeks):

- How much of what, how taken and how often?
- Primary drug, heroin in Jacky's case, and all secondary drugs: crack and benzodiazepines for Jacky

b*) Past drug history:*

- When did she start?

c) Previous Treatments

- Have they had previous treatment? What, when and for how long?
- Did they achieve abstinence and for how long?
- Why are they returning for treatment now?

d) Assessing Risk Taking Behaviour

- Is she injecting safely?
- Has she shared/lent needles, syringes or other paraphernalia
- Does she practice safe or unsafe sex and with whom?
- Is she aware of HIV, Hepatitis B and C, how these viruses are transmitted and has she been tested?
- Has she ever been immunised against hepatitis A or B?

e) Assessment of Physical Health

- Does she have any medical problems: acute, chronic?
- Has she suffered any complications of her drug use such as abscesses, thrombosis, septicaemia, fits, chest or heart problems, and hepatitis?
- Is she taking any prescribed medication?
- Has she had BP, peak flow rate, smear, and contraception check?

f) Assessment of psychological health and motivation

- What are her primary concerns?
- What does she want to change (current problem)?

g). Assessment of mental health

- Is she depressed or psychotic?
- Does she have any history of psychiatric disorder or has she had any contact with psychiatric services recently or in the past?
- Has she any history of overdoses – accidental or deliberate?

h). Assessment of social situation

- Personal relationships, partner, family, friends, children.
- Does she have any children: how many, ages, where and with whom do they live?
- Is her accommodation satisfactory: secure/homeless?
- What is her employment history?
- What is her financial situation and income?

i). Assessment of forensic history

- Has she had any contact, past or present with the criminal justice system?
- Has she even been in prison and if so when and for how long?
- How is her drug habit financed? (Remember confidentiality and explain).

B. Physical examination:

Undertaken in the normal way

C. Urine Screening

A urine drug screen is an essential safeguard and helpful tool that should always be obtained at the outset of treatment, and randomly through the course of treatment. The urine test only tells us the range of drugs being used, not how much. Some areas are now using oral swabs – these are more convenient but the drugs do not stay present for so long.

D. Other investigations

Do FBC, LFTs etc if and when appropriate.

E. Notification

Notify the patient to the local Regional Drug Misuse Database using the appropriate local reporting form, although the local shared care service will often do this or help you with it.

However for busy GPs this comes with a slight health warning, in that it can be time consuming. But although the list looks long, with practice the main areas can be covered in 10-15mins and remember you can return to it the next day. Many GPs address this by working with a drugs worker/nurse who undertakes the preliminary assessment and then you can review their findings with the patient.

Having completed the assessment you need to decide whether you feel competent and confident to manage Jacky. If not you can either ask for help in house or refer on appropriately. Always decide this before commencing substitute medication.

We feel confident that you will be able to manage Jacky and the rewards are often great. But don't forget to ask for help and participate in your local shared care scheme. Good luck and let us know how you get on.

Answer supplied by Dr Nat Wright and Dr Chris Ford

Dr Fixit on getting out of prison

Dear Dr Fixit

Paul aged 26 years, has been in treatment with me for 6 months. He returned to me after 4 weeks in prison for an outstanding charge. The prison medical officer said that they were releasing him on 25mls of methadone and requested that I continue his treatment in the community.

When he had first presented to me he had been injecting about 1 gm of heroin / day for about 5 years. He was using crack about twice a week. He was drinking about 10-12 pints of beer / week. He had never been in treatment before and settled well on 90mls of methadone daily and stopped injecting. He had gone into prison on this dose.

On leaving prison he presented to me on the same day, as I had requested. He requested to go back on his 90mls as he had not managed on 25mls and he had injected several times in prison.

Are there any particular issues that I should cover with him and should I titrate him back up to his maintenance dose?

Answer by Justin Lawson GP (The Gables Medical Group / Medical Director (YOI Castington) / GP Lead Specialist (Northumberland Community Substance Misuse Team)

This is a fairly typical scenario at present which I suspect in reality lacks the bit of detail about the patient turning up unannounced on a Friday pm having been released without healthcare in the prison knowing he'd been released. Nevertheless we will presume that communication was all that it should be!

There is a very real need to discuss harm reduction issues with respect to:

a) Risks of overdose: well done for getting him to attend the surgery so promptly on release - even in this relatively short sentence his tolerance will have gone down and he will be at risk of overdose. Post release from prison (and from detox unit) is one of the highest risk times for overdose and death.

b) Hepatitis and HIV: as yet the prison service is still in denial about the very real evidence base for needle exchanges and is very selective about applicable evidence. There is a very high risk of Hepatitis C in prison in particular and this patient needs counselling, testing and retesting within the window period. If you haven't completed his hepatitis vaccinations then do so.

c) Check that he hasn't developed a problem with any other drugs – sometimes benzodiazepines and cocaine are more readily available in prison – if he has, discuss with him and decide together how he wants to manage these.

As for the dose of methadone, it is evidently inadequate as he has had to use on top. There may have been reasons for giving him a lower dose in prison initially as a safety measure depending on his pick up and time lapse from last dose. However, there is no logic that I can think of that would have prevented him from having his dose rapidly increased to the required amount in prison, particularly after confirmation of his previous supervised pick up.

Having said that, now that he has been on 25mg for some time his tolerance may not be what it was so I would consider retitrating him from scratch. Typically he would be comfortable in 4 days or alternatively I would give him a couple of increments waiting for 5/7 for steady state and increment again until he was comfortable. I would let him choose and I would of course make sure that I had some evidence in the way of urine samples as to what he was taking. I think this evidence is important medico-legally and as well as for his individual treatment plan.

The main issue here is that the prison service often makes false assumptions about what happens in the community. There is no such thing as a generic drug service with prescribers eagerly waiting for prisoners returning from healthcare regimes developed in splendid isolation in a particular prison. I think that it is irresponsible to provide a system (even one which works whilst in prison), before communication is adequate for the purpose and before roles and responsibilities beyond the Prison are defined locally. Otherwise we have the potential to increase harm and frustrate each other. ***Frustrating indeed but hopefully positive developments are on the horizon regarding prison healthcare from next April – An excellent article by Tom Carnwath on prisons will appear in the next edition***

Good luck and how about starting improved communications with your local prison(s)?

BULLETIN BOARD

Roles and responsibilities of doctors in the provision of treatment for drug and alcohol misusers. Joint paper by RCGP and RCPsych outlining the different tiers of roles and responsibilities that doctors can hold in the field. Essential reading. Hard copies available from either college for £5.00 or available online at:

www.rcgp.org.uk/information/Text.pdf

Annual Drug & Alcohol Professionals Conference

Monday 7th November 2005 – at the Royal Institute of British Architects (London)

Organised by FDAP in association with Skills for Health and Home Office,

Drug Strategy Directorate. www.fdap.org.uk.

Contact Alan Whittemore, Conference Organiser – e-mail office@fdap.org.uk or Tel. 0870 763 6139.

This year's conference will include workshops, seminars and debates on a range of issues of relevance to the field. Topics to be covered include: NTA treatment effectiveness strategy; models of care for alcohol; residential services review; HIV & Hepatitis; nutrition and addiction; dealing with sexual abuse; prescribing interventions; engaging service users; staff training & development; DANOS drug consumption rooms; and DIP.

2nd National Conference on Sexual Health & Contraception in General Practice

'Sex in the Surgery'

Tuesday 15th November 2005 – at The Royal College of Physicians, Regents Park, London.

Organised by Sexual Health On Call. E-mail: shoc@gp-e84025.nhs.uk or Telephone 0207 604 4826.

Young people suffer disproportionately from sexual ill-health and its serious consequences. How can general practice respond to the needs of young people? How are we doing? How can we improve? Come and join the debate!

Update on Methadone Prescribing

Friday 4th November 2005 - The Thistle Tower Hotel, St Katherine's Way, London E1W 1LD.

Contact Terri Myers - drugmisuse-enquiries@rcgp.org.uk or Tel: 0207 173 6091.

A day to update primary care professionals on methadone and its uses in treatment including the official launch of RCGP guidance on the use of methadone in primary care soon to be available on www.smmgp.org.uk. Speakers include Dr Jenny Keen, Dr Chris Ford and Jim Barnard.

Celebrating General Practice

26th November 2005 at 7.30pm- Templeton Hotel, Templepatrick, N. Ireland.

Cost: £30 per person.

Contact RCGP Ireland – e-mail Val Fiddis vfiddis@rcgp.org.uk or Tel. 02890230055.

The 4th year of our celebration evening event. Awards presented to members, RCGP N.I. annual awards, top-scoring MRCGP pass in N.I., out-standing contribution awards and N.I. Practice Team of The Year 2005 award.

Locally delivered RCGP Part 1 Certificate in the Management of Drug Misuse - face-to-face events:

Manchester - 24th November 2005

Organised by Manchester Shared Care Support Team

Venue: New North Manchester Golf Club

Contact: Please e-mail Pat O'Dea for more details - podea@glentop.bstmht.nhs.uk

Cornwall - 16th November 2005

Organised by Cornwall & Isles of Scilly Shared Care Service

Venue: Eden Project Conference Centre

Contact: Please e-mail Angela Andrews for more details - Angela.Andrews@westprimcare.cornwall.nhs.uk.

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